ND

Medical Policies

Print

Policy Number:	S-179		
Policy Name:	Treatment of Abnormal Uterine Bleeding and Uterine Fibroids		
Policy Type:	Medical	**Policy Subtype:**	Surgery
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Abnormal Uterine Bleeding

Abnormal uterine bleeding (AUB) is bleeding from the uterus between periods. It may also be prolonged bleeding during a period or an extremely heavy period (menorrhagia).

Uterine Fibroids

Uterine fibroids are noncancerous growths of the uterus. Symptoms may include menorrhagia, pelvic pressure or pain. Treatment options include hysterectomy, myomectomy, uterine artery embolization and fibroid ablation.

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; or

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Criteria

Policy Application

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Coverage is subject to the specific terms of the member's benefit plan.

Transcatheter uterine artery embolization (UAE) of uterine arteries may be considered medically necessary for the treatment of uterine fibroids when any ONE of the following criteria is met:

- The individual is experiencing the following symptoms:
  - Menorrhagia (excessive menstrual bleeding lasting more than eight (8) days) as a direct result of the fibroid (i.e., not resulting from hyperplasia, atypia, or cancer) that interferes with daily activities or causes anemia; or
  - Pelvic pain or pressure as a direct result of the fibroid; or
  - Lower back pain as a direct result of the fibroid; or
  - Urinary symptoms (e.g., urinary frequency, urgency) related to compression of the bladder as a direct result of the fibroid; or
  - Gastrointestinal symptoms related to compression of the bowel (e.g., constipation, bloating) as a direct result of the fibroid; or
  - Dyspareunia (painful or difficult sexual relations) as a direct result of the fibroid; or
  - An abdominally palpable fibroid; or
  - Postpartum uterine hemorrhage; or
  - Placenta accreta, placenta increta or placenta percreta.

Or

- The individual is asymptomatic with an abdominally palpable fibroid or significantly enlarged fibroid on abdominal/vaginal examination and any ONE of the following:
  - The use of anesthesia places the individual at high surgical risk; or
  - The individual has medical contraindications to hysterectomy (e.g., morbid obesity); or
  - The use of hormonal therapy is contraindicated, or the individual is intolerant to or has previously failed a course of hormone therapy; or
  - The individual wishes to avoid hysterectomy; or
  - The individual may want to become pregnant; or
  - The individual has hydronephrosis.

One repeat transcatheter embolization of uterine arteries may be considered medically necessary to treat persistent symptoms of uterine fibroids after an initial uterine artery embolization when any ONE of the following criteria is met:

- Documentation of continued symptoms such as bleeding or pain; or
- Individual has persistent symptoms in combination with findings on imaging of an incomplete initial procedure, as evidenced by continued blood flow to the treated regions.

UAE not meeting the criteria as indicated in this policy is considered experimental/investigational, because the safety and/or effectiveness have not been established by the available published peer-reviewed literature.

Procedure Codes

36245	36246	36247	36248	37243	37244	75894

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Laparoscopic or transcervical ultrasound-guided radiofrequency ablation (e.g., Acessa ^{TM}) for the treatment of uterine fibroids may be considered medically necessary when the individual is experiencing any **ONE** of the following;

- Menorrhagia (excessive menstrual bleeding lasting more than eight (8) days) as a direct result of the fibroid (e.g., not resulting from hyperplasia, atypia, or cancer) that interferes with daily activities or causes anemia; **or**
- Pelvic pain or pressure as a direct result of the fibroid; **or**
- Lower back pain as a direct result of the fibroid; **or**
- Urinary symptoms (e.g., urinary frequency, urgency) related to compression of the bladder as a direct result of the fibroid; **or**
- Gastrointestinal symptoms related to compression of the bowel (e.g., constipation, bloating) as a direct result of the fibroid; **or**
- Dyspareunia (painful or difficult sexual relations) as a direct result of the fibroid; **or**
- An abdominally palpable fibroid.

Laparoscopic or transcervical ultrasound-guided radiofrequency ablation not meeting the criteria as indicated in this policy is considered experimental/investigational and therefore, noncovered because the safety and/or effectiveness have not been established by the available published peer-reviewed literature.

Procedure Codes

58580	58674

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

Endometrial ablation with or without hysteroscopic guidance, using an FDA-approved device, may be considered medically necessary in women who would otherwise be considered candidates for hysterectomy when any **ONE** of the following criteria are met:

- In women with menorrhagia who are not candidates for hormone therapy; **or**
- Decline hormone therapy; **or**
- Who are unresponsive to hormone therapy

Endometrial ablation with or without hysteroscopic guidance not meeting the criteria as indicated in this policy, is considered not medically necessary.

Procedure Codes

58353	58356	58563

Policy Application

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All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Treatment of uterine fibroids is considered experimental/investigational and, therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature for any **ONE** of the following procedure/services.

- Laparoscopic and percutaneous techniques for myolysis (e.g., laser and bipolar needles, cryomyolysis); **or**
- Laparoscopic uterine power morcellation in hysterectomy and myomectomy; **or**
- MRI guidance performed in conjunction with percutaneous myolysis of uterine fibroids.

Procedure Codes

58578	58999	77022

Policy Application

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Outpatient HCPCS (C Code)

C1782

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Covered Diagnosis Codes for Procedure Codes 58674 and 58580

D25.0	D25.1	D25.2	D25.9

Non-Covered Diagnosis Codes for Procedure Codes 58578; 58999; 77022 and C1782

D25.0	D25.1	D25.2	D25.9

Covered Diagnosis Codes for Procedure Codes 58353; 58356 and 58563

N92.0	N92.1	N92.4

CURRENT CODING

CPT:

36245	SLCTV CATHJ EA 1ST ORD ABDL PEL/LXTR ART BRNCH	Commercial
36246	SLCTV CATHJ 2ND ORDER ABDL PEL/LXTR ART BRNCH	Commercial
36247	SLCTV CATHJ 3RD+ ORD SLCTV ABDL PEL/LXTR BRNCH	Commercial
36248	SLCTV CATHJ EA 2ND+ ORD ABDL PEL/LXTR ART BRNCH	Commercial
37243	VASCULAR EMBOLIZE/OCCLUDE ORGAN TUMOR INFARCT	Commercial
37244	VASCULAR EMBOLIZATION OR OCCLUSION HEMORRHAGE	Commercial
58353	ENDOMETRIAL ABLTJ THERMAL W/O HYSTEROSCOPIC GUID	Commercial
58356	ENDOMETRIAL CRYOABLATION W/US & ENDOMETRIAL CR	Commercial
58563	HYSTEROSCOPY ENDOMETRIAL ABLATION	Commercial
58578	UNLISTED LAPAROSCOPY PROCEDURE UTERUS	Commercial
58580	TRANSCERVICAL ABLATION UTERINE FIBROID RF	Commercial
58674	LAPS ABLTJ UTERINE FIBROIDS W/INTRAOP US GDN	Commercial
58999	UNLISTED PX FEMALE GENITAL SYSTEM NONOBSTETRICAL	Commercial
75894	TRANSCATHETER EMBOLIZATION ANY METH RS&I	Commercial
77022	MRI GUIDANCE FOR PARENCHYMAL TISSUE ABLATION	Commercial

36245	SLCTV CATHJ EA 1ST ORD ABDL PEL/LXTR ART BRNCH	Medicaid Expansion
36246	SLCTV CATHJ 2ND ORDER ABDL PEL/LXTR ART BRNCH	Medicaid Expansion
36247	SLCTV CATHJ 3RD+ ORD SLCTV ABDL PEL/LXTR BRNCH	Medicaid Expansion
36248	SLCTV CATHJ EA 2ND+ ORD ABDL PEL/LXTR ART BRNCH	Medicaid Expansion
37243	VASCULAR EMBOLIZE/OCCLUDE ORGAN TUMOR INFARCT	Medicaid Expansion
37244	VASCULAR EMBOLIZATION OR OCCLUSION HEMORRHAGE	Medicaid Expansion
58353	ENDOMETRIAL ABLTJ THERMAL W/O HYSTEROSCOPIC GUID	Medicaid Expansion
58356	ENDOMETRIAL CRYOABLATION W/US & ENDOMETRIAL CR	Medicaid Expansion
58563	HYSTEROSCOPY ENDOMETRIAL ABLATION	Medicaid Expansion
58578	UNLISTED LAPAROSCOPY PROCEDURE UTERUS	Medicaid Expansion
58580	TRANSCERVICAL ABLATION UTERINE FIBROID RF	Medicaid Expansion
58674	LAPS ABLTJ UTERINE FIBROIDS W/INTRAOP US GDN	Medicaid Expansion
58999	UNLISTED PX FEMALE GENITAL SYSTEM NONOBSTETRICAL	Medicaid Expansion
75894	TRANSCATHETER EMBOLIZATION ANY METH RS&I	Medicaid Expansion
77022	MRI GUIDANCE FOR PARENCHYMAL TISSUE ABLATION	Medicaid Expansion

HCPCS:

C1782	Morcellator	Commercial
C1782	Morcellator	Medicaid Expansion

References

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ND Committee Review

Internal Medical Policy Committee 1-19-2021 Annual Review ***Effective March 01, 2021***

Internal Medical Policy Committee 1-20-2022 Revision ***Effective March 07, 2022***

- ***Title change*** (old title: Treatment of Abnormal Uterine Bleeding and Fibroids),
- ***Removal*** of Professional Statements and Societal Positions Guidelines
- ***Update*** to description and additional coverage criteria

Internal Medical Policy Committee 1-26-2023 Annual Review - no changes in criteria ***Effective March 06, 2023***

Internal Medical Policy Committee 7-26-2023 Revision - ***Effective September 04, 2023***

- ***Added*** two (2) additional diagnoses for Uterine artery embolization (UAE)

Internal Medical Policy Committee 1-16-2024 Revision with coding update - ***Effective January 01, 2024***

- ***Removed*** Procedure Code 0404T; **and**
- ***Added*** Procedure Code 58580; **and**
- ***Added*** minor grammatical changes.

Internal Medical Policy Committee 7-16-2024 Coding update - ***Effective September 02, 2024***

- ***Removed*** Diagnosis Codes O43.211; O43.212; O43.213; O43.221; O43.222; O43.223; O43.231; O43.232; O43.233; O44.30; O44.31; O44.32; O44.33; O44.50; O44.51; O44.52; O44.53; O72.0; O72.1 and O72.2 for Procedure Code 75894 **and**
- ***Added*** Policy Applications

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.